STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445242	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREYSTONE HEALTH CARE CENTER	181 DUNLAP ROAD, PO BOX 1133 BLOUNTVILLE, TN 37617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined corridor doors failed to close to a positive latch. The findings include: Observation and interview with the Maintenance Director, on February 25, 2012 at 2:05 p.m.confirmed the janitor's closet door across room 112 failed to close to a positive latch. Based on observation and interview, it was determined fire wall ratings are maintained. The findings include: Observation and interview with the Maintenance Director, on February 25, 2012 at 2:20 p.m. confirmed unsealed penetrations in the 2nd floor mechanical room having two sprinkler pipe wall penetrations and the 2nd floor janitor's closet exhaust duct penetration.	K 029	K029 One hour fire rated construction The faulty door latch was repaired and was functioning properly by 5pm on 2/25/13. As it had previously malfunctioned, it was replaced on 3/14/13. Penetrations were sealed on 3/1/13 and 3/13/13. Maintenance will place checking of door latches and fire walls for penetrations on weekly rounds for ongoing compliance. The QA&A Committee will receive reports from Maintenance monthly for one quarter (March, April, and May) and quarterly thereafter for two quarters.	3/15/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Jan Smith — Administrator — 3/15/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 029	Continued From page 1 These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on February 25, 2012.	K 029		
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on record review, it was determined fire drills were not conducted quarterly on each shift. The findings include: Record review on February 25, 2012 at 11:05 a.m. confirmed third shift failed to perform a fire drill the 3rd quarter of 2012. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on February 25, 2012.	K 050	K050 Fire Drills An additional 3rd shift fire drill was conducted on 3/13/13. Drills will be placed on regular schedule for at least one shift per quarter. The QA&A Committee will receive monthly reports from Maintenance monthly for one quarter (March, April, and May) and quarterly thereafter for two quarters.	3/15/13
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052		

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K 052	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation, it was determined smoke detector were not located near air flow. The findings include: Observation and interview with the Maintenance Director, on February 25, 2012 at 3:20 p.m., confirmed smoke detector in the 2nd and 3rd floor mechanical room was 2-feet directly in front of an air duct. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on February 25, 2012.	K 052	K052 Smoke detectors too near air flow The improperly placed smoke detectors were moved on 3/14/13. Maintenance checked all other detectors, and found no similar placements. The fire systems contractor will review detectors for further evidence of disturbances at each scheduled visit. QA&A will receive a documented report of the successful completion of the detector moves in its March, 2013 meeting.	3/15/13
K 077 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Piped in medical gas systems comply with NFPA 99, Chapter 4. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined medical gas cylinders were not secured. The findings include: Observation and interview with the Maintenance Director, on February 25, 2012 at 2:50 p.m., confirmed there were 24 medical gas E-cylinders in the outside Oxygen storage area that were not	K 077		

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K 077	Continued From page 3 secured. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on February 25, 2012.	K 077	K077 Medical gas systems The unsecured E-cylinders were removed from the liquid storage area on the evening of 2-25-13. All E-cylinder storage is now in appropriate E-cylinder bulk holders, labeled "full" or "empty," in a cage under the first floor west wing stairwell. Maintenance will check for proper placement of cylinders in holders, every weekday through Friday, 3/15/13, and weekly thereafter Results will be reported to the QA&A Committee for three months (March, April, and May,) then quarterly for two quarters.	3/15/13